CURLPERFECT LASH LIFT
CLIENT LIABILITY WAIVER

please initial at each line and sign at the bottom

___ I understand that there are risks associated with the CurlPerfect Lash Lift procedure.

___ I understand that the lashes will be curled with an advanced solution and a conditioning cream.

___ I understand that as part of the procedure eye irritation, pain, itching discomfort and in rare cases eye infection may occur.

___ I understand and agree to follow the aftercare instructions provided by my technician.

___ I understand failure to follow the aftercare instructions may cause an undesirable result.

___ I understand that in order to have a CurlPerfect Lash Lift, I will need to keep my eyes closed for duration up to 60 minutes during the procedure. I also understand that I will need to be lying in a reclined position. Any medical conditions that might be aggravated by lying still for a prolonged period of time may mean that I will not be able to have the procedure performed on my eyes.

___ I understand that opening my eyes at any point during the CurlPerfect Lash Lift procedure is not recommended, and may cause an undesirable result. I agree to keep my eyes closed throughout the procedure unless instructed to open them by my technician.

___ This agreement will remain in effect for this procedure and all future CurlPerfect Lash Lift procedures conducted by my technician or any other technician conducting business at the salon/spa listed below. I understand that this agreement is binding and that I have read and fully understand all information above. I represent that I am over the age of 18 years. If below 18 years of age a parent or guardian must also sign this form.

___ I release my technician or salon/spa (_____) from all liability associated with this procedure. There are no guarantees for how long the lash lift will last, on average it last between 6-8 weeks. Our company or salon is not responsible for any technician errors. I understand that I have been advised to follow the aftercare protocol from my technician so as to avoid any discomfort or adverse side effects after the procedure has been completed.

Client Signature: _____ Date: _____/_____/_____

CLIENT RECORD SHEET

DATE:

CLIENT NAME:

ADDRESS:

EMAIL:

PHOTO CONSENT: YES / NO

EMERGENCY CONTACT:

ALLERGIES AND/OR KNOWN MEDICATIONS:

PROCESS TIMES

SHIELD SIZE USED: SMALL MEDIUM LARGE

PROCESSING TIME FOR PERM LOTION:

7	8	9	10	11	12	13	14	15	(MINS)
○	○	○	○	○	○	○	○	○	

PROCESSING TIME FOR SETTING LOTION:

7	8	9	10	11	12	13	14	15	(MINS)
○	○	○	○	○	○	○	○	○	

LASH TINT USED: YES / NO

ADDITIONAL NOTES: